2015 National Training Program

Module 9
Medicare Part D Prescription Drug Coverage

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Session Objectives

This session should help you

- Differentiate Medicare Part A, Part B, and Part D drug coverage
- Summarize the Medicare Part D Benefits and Costs
- Explain Medicare Part D Drug Coverage
- Describe the LiNet Program, IRMAA and LEP
- Understand the coverage determinations and appeals process
Lesson 1—The Basics

- The 4 parts of Medicare
- Prescription drug coverage under
  - Medicare Part A (Hospital Insurance)
  - Medicare Part B (Medical Insurance)
The 4 Parts of Medicare

- **Part A**: Hospital Insurance
- **Part B**: Medical Insurance
- **Part C**: Medicare Advantage Plans (like HMOs/PPOs) Includes Part A, Part B, and sometimes Part D coverage
- **Part D**: Medicare Prescription Drug Coverage

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Medicare Prescription Drug Coverage

- Prescription drug coverage under Part A, Part B, or Part D depends on
  - Medical necessity
  - Health care setting
  - Medical indication (why you need it, like for cancer)
  - Any special drug coverage requirements
    - Such as immunosuppressive drugs following a transplant

- This information applies if you have Original Medicare
Part A Prescription Drug Coverage

- Part A generally pays for all drugs during a covered inpatient stay
  - Received as part of treatment in a hospital or skilled nursing facility
- Drugs used in hospice care for symptom control and pain relief only
Part B Prescription Drug Coverage

- Part B covers limited outpatient drugs
  - Most injectable and infusible drugs given as part of a doctor’s service
  - Drugs and biologicals
    - Used for the treatment of End-Stage Renal Disease (ESRD)
  - Drugs used at home with some types of Part B-covered durable medical equipment (DME)
    - Such as nebulizers and infusion pumps
  - Some oral drugs with special coverage requirements like
    - Certain oral anti-cancer and antiemetic drugs
    - Immunosuppressive drugs, under certain circumstances
Part B Immunization Coverage

- Part B covers certain immunizations as part of Medicare-covered preventive services
  - Flu shot
  - Pneumococcal shot (to prevent pneumonia)
  - Hepatitis B shot
- Part B may cover certain vaccines after exposure to a disease or after an injury
  - Tetanus shot
Self-Administered Drugs in Hospital Outpatient Settings

- Part B doesn’t cover self-administered drugs in a hospital outpatient setting
  - Unless needed for hospital services
- If enrolled in Part D, drugs may be covered
  - If not admitted to hospital
  - May have to pay and submit for reimbursement
Check Your Knowledge—Question 1

Prescription drugs may be covered by which of the following?

a. Part A
b. Part B
c. Part D
d. All of the above
Check Your Knowledge—Question 2

Part A covers all drugs for people receiving Medicare-covered hospice care.

a. True
b. False
Lesson 2—Medicare Part D
Benefits and Costs

- Medicare prescription drug coverage
- Medicare drug plan benefits and costs
Distribution of Sources of Prescription Drug Coverage Among Medicare Beneficiaries, 2014

Total Medicare Enrollment, 2014 = 54.0 million
Total Part D Enrollment (excluding employer plans), 2014 = 38.1 million

NOTE: LIS is low-income subsidy. Total Part D and Medicare enrollment based on 2014 intermediate estimates. Part D non-LIS enrollment includes enrollees in employer/group waiver plans (6.8 million in 2014).
Number of Medicare Part D Stand-Alone Prescription Drug Plans, by State, 2013

U.S. Total, 2013 = 1,031

23 – 29 plans: 12 states, DC
30 – 31 plans: 18 states
32 plans: 13 states
33 – 38 plans: 7 states

Medicare Drug Plans

- Can be flexible in benefit design
- Must offer at least a standard level of coverage
- Vary in costs and drugs covered
  - Different tier and/or copayment levels
  - Deductible
  - Coverage for drugs not typically covered by Part D
- Benefits and costs may change each year
# Standard Structure in 2015

Ms. Smith joins a prescription drug plan. Her coverage begins on January 1, 2015. She doesn’t get Extra Help and uses her Medicare drug plan membership card when she buys prescriptions. She pays a monthly premium throughout the year.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Smith pays the first $320 of her drug costs before her plan starts to pay its share.</td>
<td>Ms. Smith pays a copayment, and her plan pays its share for each covered drug until their combined amount (plus the deductible) reaches $2,960.</td>
<td>Once Ms. Smith and her plan have spent $2,960 for covered drugs, she’s in the coverage gap. In 2015, she pays 45% of the plan’s cost for her covered brand-name prescription drugs and 65% of the plan’s cost for covered generic drugs. What she pays (and the discount paid by the drug company) counts as out-of-pocket spending, and helps her get out of the coverage gap.</td>
<td>Once Ms. Smith has spent $4,700 out of pocket for the year, her coverage gap ends. Now she only pays a small coinsurance or copayment for each covered drug until the end of the year.</td>
</tr>
</tbody>
</table>
## Improved Coverage in the Coverage Gap

<table>
<thead>
<tr>
<th>Year</th>
<th>What You Pay for Covered Brand-Name Drugs in the Coverage Gap</th>
<th>What You Pay for Covered Generic Drugs in the Coverage Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>45%</td>
<td>65%</td>
</tr>
<tr>
<td>2016</td>
<td>45%</td>
<td>58%</td>
</tr>
<tr>
<td>2017</td>
<td>40%</td>
<td>51%</td>
</tr>
<tr>
<td>2018</td>
<td>35%</td>
<td>44%</td>
</tr>
<tr>
<td>2019</td>
<td>30%</td>
<td>37%</td>
</tr>
<tr>
<td>2020</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>
True Out-of-Pocket (TrOOP) Costs

- Expenses that count toward your out-of-pocket threshold ($4,700 in 2015)
- After threshold you get catastrophic coverage
  - You pay only small copayment or coinsurance for covered drugs
- Explanation of Benefits (EOB) shows TrOOP costs to date
- TrOOP transfers if you switch plans mid-year
### Income-Related Monthly Adjustment Amount (IRMAA)

<table>
<thead>
<tr>
<th>Your Yearly Income in 2013 Filing an Individual Tax Return</th>
<th>Your Yearly Income in 2013 Filing a Joint Tax Return</th>
<th>In 2015 You Pay Monthly</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
<td>Your Plan Premium (YPP)</td>
</tr>
<tr>
<td>Above $85,000</td>
<td>Above $170,000</td>
<td>YPP + $12.30*</td>
</tr>
<tr>
<td>Up to $107,000</td>
<td>Up to $214,000</td>
<td></td>
</tr>
<tr>
<td>Above $107,000</td>
<td>Above $214,000</td>
<td>YPP + $31.80*</td>
</tr>
<tr>
<td>Up to $160,000</td>
<td>Up to $320,000</td>
<td></td>
</tr>
<tr>
<td>Above $160,000</td>
<td>Above $320,000</td>
<td>YPP + $51.30*</td>
</tr>
<tr>
<td>Up to $214,000</td>
<td>Up to $428,000</td>
<td></td>
</tr>
<tr>
<td>Above $214,000</td>
<td>Above $428,000</td>
<td>YPP + $70.80*</td>
</tr>
</tbody>
</table>

IRMAA is adjusted each year, as it’s calculated from the annual beneficiary base premium.

05/01/2015  Medicare Prescription Drug Coverage  24
When the coverage gap improvements are reached in 2020, you’ll pay the following percent for covered generic and brand-name drugs.

a. Brand-name 30%, Generic 37%

b. Brand-name 20%, Generic 20%

c. Brand-name 25%, Generic 25%

d. Brand-name 35%, Generic 44%
Part A covers flu vaccines.

a. True
b. False
Lesson 3—Medicare Part D
Drug Coverage

- Covered and non-covered drugs
- Access to covered drugs
- Medication Therapy Management
Part D Covered Drugs

- Prescription brand-name and generic drugs
  - Approved by the U.S. Food and Drug Administration
  - Used and sold in United States
  - Used for medically-accepted indications
- Includes drugs, biological products, and insulin
  - And supplies associated with injection of insulin
- Plans must cover a range of drugs in each category
- Coverage and rules vary by plan
Required Coverage

- All drugs in 6 protected categories
  1. Cancer medications
  2. HIV/AIDS treatments
  3. Antidepressants
  4. Antipsychotic medications
  5. Anticonvulsive treatments
  6. Immunosuppressants

- All commercially available vaccines
  - Except those covered under Part B (e.g., flu shot)
Drugs Excluded by Law Under Part D

- Drugs for anorexia, weight loss, or weight gain
- Erectile dysfunction drugs when used for the treatment of sexual or erectile dysfunction
- Fertility drugs
- Drugs for cosmetic or lifestyle purposes
- Drugs for symptomatic relief of coughs and colds
- Prescription vitamin and mineral products
- Non-prescription drugs
Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

Tier Structure Example

<table>
<thead>
<tr>
<th>Tier</th>
<th>You Pay</th>
<th>Prescription Drugs Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lowest copayment</td>
<td>Most generics</td>
</tr>
<tr>
<td>2</td>
<td>Medium copayment</td>
<td>Preferred, brand name</td>
</tr>
<tr>
<td>3</td>
<td>High copayment</td>
<td>Non-preferred, brand name</td>
</tr>
<tr>
<td>4 or Specialty</td>
<td>Highest copayment or coinsurance</td>
<td>Unique, very high cost</td>
</tr>
</tbody>
</table>
Formulary Changes

- Plans may only change categories and classes at the beginning of each plan year
  - May make maintenance changes during year
    - Such as replacing brand-name drug with new generic
- Plan usually must notify you 60 days before changes
  - You may be able to use drug until end of calendar year
  - May ask for exception if other drugs don’t work
- Plans may remove drugs withdrawn from the market by the FDA or the manufacturer without a 60-day notification
## How Plans Manage Access to Drugs

<table>
<thead>
<tr>
<th>Prior Authorization</th>
<th>▪ Doctor must contact plan for prior approval and show medical necessity for drug before drug will be covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step Therapy</td>
<td>▪ Must first try similar, less expensive drug</td>
</tr>
<tr>
<td></td>
<td>▪ Doctor may request an exception if</td>
</tr>
<tr>
<td></td>
<td>• Similar, less expensive drug didn’t work, or</td>
</tr>
<tr>
<td></td>
<td>• Step therapy drug is medically necessary</td>
</tr>
<tr>
<td>Quantity Limits</td>
<td>▪ Plan may limit drug quantities over a period of time for safety and/or cost</td>
</tr>
<tr>
<td></td>
<td>▪ Doctor may request an exception if additional amount is medically necessary</td>
</tr>
</tbody>
</table>
Requirement for Prescribers

- CY 2015 final rule issued May 23, 2014 requires prescribers of Part D drugs
  - Be enrolled in an approved status, or
  - Have a valid opt-out affidavit on file for their prescriptions to be covered under Part D
- The May 1, 2015, interim final rule changed enforcement date to January 1, 2016
Medicare Therapy Management

- A pharmacist or other health professional does a comprehensive review of all your medications and talks with you about
  - How to get the most benefits from the drugs you take
  - Any concerns you have, like medication costs and drug reactions
  - How best to take your medications
  - Any questions or problems you have about your prescription and over-the-counter medication

- Your drug plan may enroll you if you meet all of these conditions:
  1. You have more than one chronic health condition
  2. You take several different medications
  3. Your medications have a combined cost of more than $3,017 per year
Prescribers must ____________________ or ____________________ to prescribe Part D drugs starting December 1, 2015.

a. Enroll in Medicare and be in good standing
b. Enroll in Medicaid and be in good standing
c. Opt out of Medicare
d. a and c
Check Your Knowledge—Question 6

Which of the following is NOT a condition for a Part D plan to enroll you in Medication Therapy Management?

a. You have more than one chronic health condition
b. You live alone
c. You take several different medications
d. Your medications have a combined cost of more than $3,017 per year
Part D Late Enrollment Penalty

- Higher premium if you wait to enroll
  - Exceptions if you have
    - Creditable coverage
    - Extra Help
- Pay penalty for as long as you have coverage
  - 1% of base beneficiary premium ($33.13 in 2015)
    - For each full month eligible and not enrolled
  - Amount changes every year
Ann didn’t join when she was first eligible—by June 2012, and she has no drug coverage from any other source. She joined a Medicare drug plan during the 2014 Open Enrollment Period. Her coverage began on January 1, 2015.

She was without creditable prescription drug coverage from July 2012–December 2014. Her penalty in 2015 is 30% (1% for each of the 30 months) of $33.13 (the national base beneficiary premium for 2015), which is $9.93. The monthly penalty is rounded to the nearest $.10, so she’ll be charged $9.90 each month in addition to her plan’s monthly premium in 2015.

Here’s the math:

\[ 0.30 \times \$33.13 = \$9.93 \]

$9.93 (rounded to the nearest $0.10) = \$9.90

\$9.90 = Ann’s monthly late enrollment penalty for 2015
Medicare’s Limited Income Newly Eligible Transition (NET) Program

- Designed to remove gaps in coverage for low-income individuals moving to Part D coverage
- Gives temporary drug coverage if you have Extra Help and no Medicare drug plan
- Coverage may be immediate, current, and/or retroactive
- Medicare’s Limited Income NET Program
  - Has an open formulary
  - Doesn’t require prior authorization
  - Includes standard safety and abuse edits
    - To protect you from refilling too soon or therapy duplication
  - Has no network pharmacy restrictions
- Continuing Education credit webinars available
  - Run by Humana
How Do You Access Medicare’s Limited Income NET Program?

Auto-enrollment by CMS
• CMS auto-enrolls you if you have Medicare and get either full Medicaid coverage or SSI benefits.

Point-of-Sale (POS) Use
• You may use Medicare’s Limited Income NET Program at the pharmacy counter (point-of-sale).

Submit a Receipt
• You may submit pharmacy receipts (not just a cashier’s receipt) for prescriptions already paid for out of pocket during eligible periods.
Step 3: Decide and Join

- Decide which plan is best for you and enroll
  - Online enrollment
    - Medicare.gov/find-a-plan/questions/home.aspx
    - Plan’s website
  - Enroll by phone
    - 1-800-MEDICARE (1-800-633-4227)
      - TTY users should call 1-877-486-2048
    - Call plan
  - Mail or fax paper application to plan
Lesson 7—Coverage Determinations and Appeals

- Coverage determinations
- Exception requests
- Appeals
Coverage Determination Request

- Initial decision by plan
  - Which benefits you’re entitled to get
  - How much you have to pay for a benefit
  - You, your prescriber, or your appointed representative can request it

- Time frames for coverage determination request
  - May be standard (decision within 72 hours)
  - May be expedited (decision within 24 hours) if life or health may be seriously jeopardized
Exception Requests

- Two types of exceptions
  1. Formulary exceptions
     - Drug not on plan’s formulary, or
     - Access requirements (for example, step therapy)
  2. Tier exceptions
     - For example, getting a tier 4 drug at tier 3 cost
- Need supporting statement from prescriber
- You, your appointed representative, or prescriber can make requests
- Exception may be valid for rest of year
Requesting Appeals

- If your coverage determination or exception is denied, you can appeal the plan’s decision.
- In general, you must make your appeal requests in writing.
  - Plans must accept oral (spoken) expedited requests.
- An appeal can be requested by:
  - You
  - Your doctor or other prescriber
  - Your appointed representative
- There are 5 levels of appeals.
Appendix A: Part D Appeals

**Standard Process**
- Initial Decision: 72 hour time limit
- First Level of Appeal: MA-PDP/PDP Redetermination, 7 day time limit
- Second Level of Appeal: Part D IRE Reconsideration, 7 day time limit
- Third Level of Appeal: Office of Medicare Hearing and Appeals, ALJ Hearing Decision, AIC => $150, 90 day time limit
- Fourth Level of Appeal: Medicare Appeals Council, 90 day time limit
- Final Appeal Level: Federal District Court, AIC => $1,460

**Expedited Process**
- Initial Decision: 24 hour time limit
- First Level of Appeal: MA-PDP/PDP Redetermination, 72 hour time limit
- Second Level of Appeal: Part D IRE Reconsideration, 72 hour time limit
- Third Level of Appeal: Office of Medicare Hearing and Appeals, ALJ Hearing Decision, AIC => $150, 10 day time limit
- Fourth Level of Appeal: Medicare Appeals Council, Expedited Decision, 10 day time limit
- Final Appeal Level: Federal District Court, AIC => $1,460
a: Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days

b: The AIC requirement for all ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.

c: A request for a coverage determination includes a request for a tiering exception or a formulary exception

AIC = Amount in Controversy
ALJ = Administrative Law Judge
MA-PD = Medicare Advantage Prescription Drug

A request for a coverage determination may be filed by the enrollee, the enrollee’s appointed representative, Prescription Drug Plan (PDP) or the enrollee’s physician.

The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication time frame begins when the plan sponsor gets the physician’s supporting statement.

IRE = Independent Review Entity

This chart reflects the CY 2015 AIC amounts.
Key Points to Remember

✓ Medicare Part D provides your Medicare prescription drug coverage
✓ You must take action to join a plan
✓ A delay in joining may result in a late enrollment penalty
✓ You have choices in how you get your coverage
✓ Extra Help is available to people with low income and resources
<table>
<thead>
<tr>
<th>Resources</th>
<th>Medicare Products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Websites:</strong></td>
<td><strong>Partner Tip Sheets (continued)</strong></td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (CMS) CMS.gov</td>
<td>&quot;Medicare Drug Coverage Under Medicare Part A, B, &amp; D&quot; (CMS Product No. 11315-P)</td>
</tr>
<tr>
<td>RxAssist - A directory of Patient Assistance Programs rxassist.org</td>
<td>&quot;Handling Medicare Part D Complaints&quot; (CMS Product No. 11259-P)</td>
</tr>
<tr>
<td>Medicare Part D Appeals MedicarePartDAppeals.com</td>
<td>&quot;How Retiree Coverage Works With Medicare Prescription Drug Coverage&quot; (CMS Product No. 11403-P)</td>
</tr>
<tr>
<td><strong>Contacts:</strong></td>
<td>&quot;Correcting Subsidy Status or Level Based on Best Evidence&quot; (CMS Product No. 11325-P)</td>
</tr>
<tr>
<td>Medicare.gov</td>
<td>&quot;Information Partners Can Use On: Closing the Coverage Gap&quot; (CMS Product No. 11495-P)</td>
</tr>
<tr>
<td>1-800-MEDICARE (1-800-633-4227)</td>
<td>&quot;Information Pharmacists Can Use On: Closing the Coverage Gap&quot; (CMS Product No. 11522-P)</td>
</tr>
<tr>
<td>1-877-486-2048 (TTY)</td>
<td>&quot;LI NET for People at Pharmacy Counter&quot; (CMS Product No. 11328-P)</td>
</tr>
<tr>
<td>Social Security</td>
<td>&quot;LI NET for People With Retroactive Medicaid &amp; SSI Eligibility&quot; (CMS Product No. 11401-P)</td>
</tr>
<tr>
<td>1-800-772-1213</td>
<td>&quot;How Medicare Plans Drug Coverage Work With a Medicare Advantage Plan or Medicare Cost Plan&quot; (CMS Product No. 11135)</td>
</tr>
<tr>
<td>socialsecurity.gov</td>
<td><strong>Manuals/Guidance (continued)</strong></td>
</tr>
<tr>
<td>Email: <a href="mailto:linetoutreach@humana.com">linetoutreach@humana.com</a></td>
<td>National Training Program – Partner Job Aids Visit the Training Library at CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram</td>
</tr>
<tr>
<td><strong>Manuals/Guidance</strong></td>
<td>CMS Publications &quot;Your Guide to Medicare Prescription Drug Coverage&quot; (CMS Product No. 11109)</td>
</tr>
<tr>
<td>&quot;Prescription Drug Benefit Manual” CMS.gov/Medicare/prescription-drug-coverage/prescriptiondrugcovcontra/partdmanuals.html</td>
<td>“Things to Think About When You Compare Medicare Drug Coverage” (CMS Product No. 11163)</td>
</tr>
<tr>
<td>&quot;PDP Enrollment and Disenrollment Guidance” CMS.gov/Medicare/eligibility-and-enrollment/medicareprespdrugeligenrol/index.html</td>
<td>“4 Ways to Help Lower Your Medicare Prescription Drug Costs” (CMS Product No. 11417)</td>
</tr>
<tr>
<td></td>
<td>To view or order these products: Single copies—CMS.gov/Publications, Multiple copies (partners only) productordering.cms.hhs.gov</td>
</tr>
</tbody>
</table>

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